

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 16 March 2004

In the Matter of:

OTIS JOHN FIELDS,
Claimant,
v.

CASE NO: 2003BLA5353

OLD DOMINION ENERGY CORPORATION,
Employer,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-In-Interest

Appearances:

Joseph Wolfe, Esquire
W. Andrew Delph, Jr., Esquire
For the Claimant

Robert M. Himmel, Esquire
For the Employer

Before: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER – REJECTION OF CLAIM

Statement of the Case

This proceeding involves a first claim for benefits under the Black Lung Benefits Act, as amended, 30 U.S.C. 901 *et seq.* ("the Act") and the regulations promulgated thereunder.¹ Since

¹ The Department of Labor has amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969. These regulations became effective on January 19, 2001, and were published at 65 Fed. Reg. 80,045-80, 107 (2000)(codified at 20 CFR Parts 718, 722, 725,

Claimant filed this application for benefits after January 1, 1982, Part 718 applies. §718.2. Since the claim was filed after the effective date, January 19, 2001, of the December 20, 2000, amendments to Parts 718 and 725, consideration of the claim is governed by the amendments in accordance with their terms. Because the Claimant was last employed in coal mine work in the state of Virginia, the law of the United States Court of Appeals for the Fourth Circuit controls. *See Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

The instant claim was filed by Otis John Fields (the “Claimant”), on February 15, 2001 (D-2). In a Proposed Decision and Order dated October 1, 2002, followed by an Initial Determination dated October 29, 2002, the District Director awarded benefits to Claimant (D-36, 40). In a letter dated October 23, 2002, Old Dominion Energy Corporation (the “Employer”) requested a hearing before an administrative law judge (D-39). The parties agreed to waive their rights to a formal hearing; the hearing scheduled on May 13, 2003, in Abingdon, Virginia, was canceled; and this tribunal directed that the decision be rendered on the written record by order dated May 19, 2003. Both parties were represented by counsel. Only Employer submitted an Evidence Summary Form as directed. Claimant is in pay status.

Issues

1. Whether Claimant has coal workers' pneumoconiosis?
2. Whether Claimant has proved the existence of complicated coal workers pneumoconiosis?
3. Whether Claimant's pneumoconiosis, if proved, arose out of his coal mine employment?
4. Whether Claimant is totally disabled by a respiratory or pulmonary impairment?
5. Whether Claimant's total disability, if proved, is due to coal worker's pneumoconiosis?

Findings of Fact

Background and Length of Coal Mine Employment

Claimant was born on April 30, 1954, and completed the twelfth grade of education (D-2). Claimant married Ginger Fields on January 2, 1976 and there is no evidence that they are not still married and living together (D-2, 7). Claimant also has a dependent son who is over eighteen, but is attending full time an approved institution of higher learning. (D-44) Claimant alleged that he completed twenty-three years of coal mine employment (D-1). The District Director found that Claimant had established approximately twenty-two years of coal mine employment (D-46). Claimant's Social Security records and employment history indicate that Claimant completed approximately twenty-three years of coal mine employment, and, therefore, this tribunal finds that Claimant has established twenty-three years of coal mine employment (D-3, 5). Claimant last worked in the coal mines for Employer in 1999 as a continuous miner and scoop operator (D-1, 2, 4). He is a lifelong nonsmoker. (D-11)

and 726). All citations to the regulations, unless otherwise indicated, refer to the amended regulations. The Director's exhibits are denoted “D-”; and Employer's exhibits, as “E”.

Medical Evidence

Chest X-ray Evidence²

Exh. No.	X-ray Date	Physician	Qualifications	Film Quality	Interpretation
D-11	3/29/01	Patel	R/B	1	1/2, t/t, size A large opacity, 2.5 x 1 cm. left upper lung
D-11	3/29/01	Navani	R/B	2	Film read for quality only
D-30	1/31/02	DePonte	R/B	1	1/0, s/t, size A large opacity, 4 cm. right lower lung
E-1	1/31/02	Scott	R/B	2	0/0
E-2	1/31/02	Wheeler	R/B	2	0/0

Pulmonary Function Studies³

Exh. No.	Test Date	Age/ Ht.	Physician	Co-op./ Undst./ Conf.?	FEV1	FVC	MVV	Qualify
D-11	3/29/01	46/ 71"	Rasmussen	Good/ Good/ Yes	2.85 2.70	3.68 3.73	84 128	No No

Arterial Blood Gas Studies⁴

Exh. No.	Test Date	Physician	Conform?	pO2	pCO2	Qualifying
D-11	3/29/01	Rasmussen	Yes	37 33	70 69	No No

² The following abbreviations are used in describing the qualifications of the physicians: B-reader, "B"; board-certified radiologist, "R". An interpretation of "0/0" signifies that the film was read completely negative for pneumoconiosis.

³ The second set of values indicates post-bronchodilator studies.

⁴ The second set of values indicates the exercise portion of the study.

Medical Opinions

Because the existence of complicated pneumoconiosis is at issue, the details of the available x-ray interpretations assume particular significance. Although the interpretations do not technically qualify as medical reports under the applicable regulations, §725.414(a)(1), they are treated together with Dr. Rasmussen's medical report under this heading.

*Dr. Rasmussen*⁵

In the only medical examination report of record dated March 29, 2001, Dr. Rasmussen, who is board-certified in internal medicine and a B-reader, opined that Claimant has moderate loss of lung function, and that he does not retain the pulmonary capacity to perform his last regular coal mine job; that Claimant has a significant history of exposure to coal mine dust, and x-ray changes supporting a medically reasonable conclusion that he has complicated pneumoconiosis, Category A; and that the two probable risk factors for Claimant's impaired lung function are his previous pleural effusion/fibrosis, and his coal mine dust exposure, a significant contributing factor. (D-11) In addition to Claimant's coal mine dust exposure, Dr. Rasmussen based his assessment of complicated pneumoconiosis on Dr. Patel's 1/2 t/t, Category A, classification of the March 29, 2001, x-ray. That x-ray was subsequently compared by Dr. Patel with a copy of a 1992 Department of Labor film, and interpreted as indicating progressive interval change consistent with complicated pneumoconiosis. Dr. Rasmussen also diagnosed chronic bronchitis. He opined that the etiology of the coal workers' pneumoconiosis (CWP) and chronic bronchitis were coal mine dust exposure, and that the etiology of the pleural fibrosis was non-occupational.

Dr. Rasmussen noted that Claimant was a lifelong nonsmoker who had worked as a coal miner for approximately twenty-three years ending in 1999, last working as a miner operator performing considerable heavy manual labor. In this regard Dr. Rasmussen recorded that Claimant operated a continuous miner and other equipment, but he also shoveled the belt line, built stoppings, loaded and unloaded supplies, and rock dusted, carrying fifty pound rock dust bags a distance of seventy feet.

Dr. Rasmussen observed that a pulmonary function study demonstrated minimal irreversible restrictive ventilatory impairment, with minimally reduced maximum breathing capacity that increased significantly following administration of a bronchodilator. However, he recorded moderately reduced single breath carbon monoxide diffusing capacity, and minimal impairment in oxygen transfer at rest. A treadmill exercise study achieved 59% of Claimant's predicted maximum oxygen uptake, but did not identify his anaerobic threshold, though Claimant's volume of ventilation was normal, and impairment in oxygen transfer was moderate with exercise. Dr. Rasmussen based his conclusion that Claimant lacked the pulmonary capacity

⁵ This tribunal has taken judicial notice of Dr. Rasmussen's qualifications by reference to the worldwide web, American Board of Medical Specialties, Who's Certified Results, at <http://www.abms.org>, and the List of NIOSH Approved B Readers, found, *inter alia*, at <http://www.oalj.dol.gov/libbla.htm>. See *Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 B.L.R. 1-135 (1990).

to perform his last regular coal mine job on these studies which, he opined, indicated moderate loss of lung function.

X-ray Interpretation of Dr. Patel

Dr. Patel interpreted the chest x-ray film taken March 29, 2001, giving an impression of the film as quality 1, classified 1/2, t/t, affecting all lung zones, associated with bilateral diffuse pleural thickening and blunted costophrenic angles classifiable as pneumoconiosis. He noted retraction and disorganization of the pulmonary architecture in the lower lung zones, and an elongated, noncalcified density, 2.5 x 1 cm., in the left upper lung zone, which he identified as “likely a developing Category A large opacity of complicated pneumoconiosis.” At Dr. Rasmussen’s instigation Dr. Patel subsequently compared that film with an unidentified and undated photocopy of an x-ray from the Department of Labor presumed to have been taken in 1992, noting, *inter alia*, that the 2.5 x 1 cm. density was new. (D-11) Notably, there was no mention of a large opacity in the lower right lung. This x-ray dated March 29, 2001, was not reread, and so Dr. Patel’s interpretation is not contradicted.

X-ray Interpretation of Dr. DePonte

Dr. DePonte, who is a board-certified diagnostic radiologist and B-reader, interpreted a more recent chest x-ray dated January 31, 2002, as grade 1 quality, classified 1/0, s/t, with small irregular opacities present in all lung zones, and a four centimeter opacity present in the right lower lung zone which “could represent a large opacity of pneumoconiosis but the location is atypical.” She noted that “the right hilum is slightly enlarged and this lesion in the right lower lobe is suspicious for a primary bronchogenic neoplasm.” Like Dr. Patel she noted the blunted costophrenic angles, but unlike Dr. Patel she observed no diffuse pleural thickening and did not mention a large opacity in the upper left lung.

In her deposition dated February 19, 2003, Dr. DePonte testified that she had observed a large opacity, category A, in the right lower lung zone, and suggested that the four centimeter mass could be carcinoma, because at that location it was atypical for a conglomerate mass. Dr. DePonte testified that the vast majority of complicated conglomerate masses in pneumoconiosis occur in the upper lung zone, because that is generally where the greatest dust disposition occurs and that it is “uncommon, but not totally unrealistic,” to see them in the lower lung zone. She testified that she had seen “a few cases, a handful perhaps, in which they have been in the ...lower lung zone,” in seventeen and a half years of medical practice. When asked whether the four centimeter opacity was more consistent with a carcinoma or with pneumoconiosis, she responded, “It is hard to tell because the opacity is not clearly seen. I mean, part of it is...because it’s in the lower lung zone, and there’s some pleural abnormalities also over that, it’s hard to say exactly what the etiology of this is.” She then responded to the question, whether a complicated pneumoconiosis lesion or opacity was more likely than not, “From a medical standpoint, I think this is most likely something else...other than a conglomerate mass [of pneumoconiosis],” and suggested the possibility of lung cancer. Dr. DePonte also declared that Claimant did not have the typical rounded opacities of black lung. Dr. DePonte stated that it is difficult to make a clear diagnosis without CT scans or multiple x-rays, and suggested that the pleural abnormalities observed could be related to asbestosis as well as pneumoconiosis, if there were an appropriate history of exposure. (E-3).

X-ray Interpretations of Dr. Wheeler and Dr. Scott

Dr. Wheeler and Dr. Scott interpreted the chest x-ray dated January 31, 2002, which was interpreted by Dr. DePonte, but not by Dr. Patel. Dr. Wheeler interpreted the x-ray as slightly underexposed, quality 2, and without parenchymal or pleural abnormalities consistent with pneumoconiosis. However, he expressly noted abnormalities including a possible 4 cm. mass or infiltrate in the inferior medial right lung and recommended a CT scan. He also noted “Moderate pleural fibrosis blunting left lateral CPA and small linear discoid atelectasis above it involving lateral pleura and minimal pleural fibrosis blunting lateral portion right CPA compatible with healed inflammatory disease. Tiny linear scar in lateral RUL involving subtle thickened lateral pleural near mid scapula and tiny vertical linear scar in LUL.” Thus he appeared to identify the same 4 cm. mass in the lower right lung identified by Dr. DePonte, but does not appear to have identified the 2.5 x 1 cm. opacity in the upper left lung identified by Dr. Patel in the x-ray taken approximately nine months earlier.

Dr. Scott interpreted the January 31, 2002, chest x-ray as underexposed, quality 2, and, like Dr. Wheeler, without parenchymal or pleural abnormalities consistent with pneumoconiosis. The other abnormalities noted were “Probably linear scars lateral right upper lung and left lower lung. Minimal bilateral CPA – blunting due to pleural fibrosis or small effusions. Changes probably due to healed infection.” Thus, he, like Dr. Wheeler, Dr. DePonte, and Dr. Patel, noted the blunting of the costophrenic angles, but did not identify either the 4 cm. opacity identified by Dr. DePonte and Dr. Wheeler, or the 2.5 x 1 cm. earlier identified by Dr. Patel, on this x-ray.

Conclusions of Law and Discussion

Elements of Entitlement to Benefits

Benefits under the Act are awardable to persons who are totally disabled due to pneumoconiosis within the meaning of the Act. For the purposes of the Act, pneumoconiosis, commonly known as black lung, means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. It includes diseases recognized by the medical community as pneumoconioses, as well as any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment. A disease arising out of coal mine employment includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. §718.201. In order to obtain federal black lung benefits, a claimant miner must prove by a preponderance of the evidence that: “(1) he has pneumoconiosis; (2) the pneumoconiosis arose out of his coal mine employment; (3) he has a totally disabling respiratory or pulmonary condition; and (4) pneumoconiosis is a contributing cause of his total respiratory disability.” *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 529, 21 B.L.R. 2-323 (4th Cir. 1998); see *Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1195, 19 B.L.R. 2-304 (4th Cir. 1995); 20 CFR §§718.201-.204 (1999); *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

Existence of Pneumoconiosis

For the purposes of the Act, “pneumoconiosis” means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising from coal mine employment. This definition includes both medical, or “clinical,” pneumoconiosis and statutory, or “legal,” pneumoconiosis. See §718.201. Section 718.202(a) prescribes four bases for finding the existence of pneumoconiosis: (1) a properly conducted and reported chest x-ray; (2) a properly conducted and reported biopsy or autopsy; (3) reliance upon certain presumptions which are set forth in §§718.304, 718.305, and 718.306; or (4) the finding by a physician of pneumoconiosis as defined in §718.201 which is based upon objective evidence and a reasoned medical opinion. Since the record contains no evidence of a biopsy or autopsy, the existence of pneumoconiosis cannot be established under §718.202(a)(2). Since the claim was filed after January 1, 1982, and since this is not a survivor’s claim, the presumptions set forth in §§718.305 and 718.306 are inapplicable.

Applicability of the Presumption Set Forth at §718.304

Section 718.304 provides an irrebuttable presumption that the miner is totally disabled by, or that the miner’s death was due to, pneumoconiosis if the miner is suffering or suffered from a chronic dust disease of the lungs of an advanced degree frequently referred to as complicated pneumoconiosis. See *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7, 11 (1996); *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250, 255 (4th Cir. 2000). Section 718.304 sets out three methods by which a claimant may establish the existence of complicated pneumoconiosis: a) diagnosis by x-ray yielding one or more large opacities classified in Category A, B, or C in the International Classification of Radiographs of the Pneumoconioses by the International Labor Organization; b) diagnosis by biopsy or autopsy yielding massive lesions in the lungs; or c) when diagnosis by means other than those specified by (a) and (b) would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) had diagnosis been made as therein described. Any diagnosis made under paragraph (c) must accord with acceptable medical procedures. §718.304(c). The Benefits Review Board has held that §718.304(a)-(c) do not provide alternative means of establishing the irrebuttable presumption of total disability due to pneumoconiosis. Rather, the Board requires the administrative law judge first to evaluate the evidence in each category, and then to weigh together the categories at §718.304(a)-(c) prior to invocation. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (*en banc*).

The Court in *Scarbro* stated that “the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they appear to be perhaps because of an intervening pathology, some technical problem with the equipment used, or incompetence of the reader.” *Scarbro* at 256. Since the only relevant objective evidence of complicated pneumoconiosis in the instant record pertains to the interpretations of x-rays under prong (a) of §718.304, the requisite equivalency determinations with respect to prongs (b) and (c) are unnecessary. Because the x-ray evidence is subject to defects enumerated in *Scarbro*, the x-ray evidence of large opacities is inconclusive at best, and there has been a failure of proof.

X-ray Evidence under §718.304(a)

The relevant medical evidence of record is limited in this case. Dr. Rasmussen's diagnosis of complicated pneumoconiosis is dependent upon Dr. Patel's interpretation of the March 29, 2001, x-ray taken at the time of Dr. Rasmussen's examination of the Claimant. Dr. Rasmussen produced the only medical report of record. There is no evidence of follow up by CT scan, or other medical technology, of either the 2.5 x 1 cm. opacity as recommended by Dr. Patel, or the four centimeter large opacity as recommended separately by Dr. DePonte and Dr. Wheeler. There is no rereading of Dr. Patel's x-ray of March 29, 2001. And Dr. DePonte, in making an equivocal assessment, noted the lack of reliable evidence, other than the single x-ray that she interpreted, which would be needed to make a secure diagnosis.

The record contains four interpretations of two chest x-rays by four physicians,⁶ all of whom were dually qualified as board-certified radiologists and B-readers. Drs. Patel and DePonte interpreted two separate films, the March 29, 2001, and January 31, 2002, x-rays respectively, as positive for pneumoconiosis, each with a size A large opacity. But each opacity was of a different size and was in a distinctly different location. Dr. Wheeler read the January 31, 2002 x-ray as negative for pneumoconiosis, but noted a possible four centimeter mass or infiltrate in the inferior medial right lung. That observation tends to corroborate Dr. DePonte's finding as to the existence of the opacity, though Dr. Wheeler indicated without elaboration that the opacity is not related to coal workers' pneumoconiosis. Dr. Scott interpreted the January 31, 2002, x-ray as negative for pneumoconiosis, and did not identify any large masses. Thus, the reliability of his x-ray interpretation is in doubt, though it tends to corroborate the absence of the 2.5 x 1 cm. opacity identified by Dr. Patel in the upper left lung from the more recent x-ray

The March 29, 2001, x-ray read by Dr. Patel was not reread by any other physician, and so is not expressly contradicted. However, his identification of the 2.5 x 1 cm. opacity in the upper left lobe of Claimant's lung, which he characterized as "likely a developing category A large opacity of complicated pneumoconiosis," is not corroborated by any other evidence. There is no indication that Dr. Rasmussen considered an interpretation other than Dr. Patel's. Dr. Patel's choice of the word "likely" suggests that his conclusion was not definitive. He did not confirm or reassess his diagnosis nine months later by interpreting the January 31, 2002, x-ray. The fact that none of the three comparably qualified interpreters of the January 31, 2002, x-ray taken approximately nine months later refer to the 2.5 x 1 cm. opacity tends to prove by negative implication that the lesion was not there or had resolved, and, therefore, would have been an intervening pathology and would not have been related to coal workers' pneumoconiosis, a progressive and incurable disease. The interpretations of a more recent x-ray, even though only nine months more recent, are credible in this regard. Thus, this tribunal finds that Dr. Patel's interpretation has been effectively impeached to the extent that it purports to establish the existence of complicated pneumoconiosis, and that there is not a preponderance of evidence which establishes the existence of complicated pneumoconiosis on the basis of the 2.5 x 1 cm. opacity in the upper left lobe identified by Dr. Patel.

⁶ Dr. Navani read an x-ray for quality only.

The evidence of complicated pneumoconiosis derived from the x-ray dated January 31, 2002, in which two qualified readers identified a four centimeter opacity in Claimant's lower right lung, also does not support a finding of complicated coal workers' pneumoconiosis. Because of her serious reservations, Dr. DePonte's diagnosis is essentially equivocal as to the character of the four centimeter opacity, and her tentative diagnosis, in effect, of possible complicated coal workers' pneumoconiosis is uncorroborated. Significantly, she hedged her initial finding in her deposition testimony by suggesting that she had little confidence in the diagnosis of complicated pneumoconiosis beyond the existence of a large four centimeter opacity, because the location of the opacity in the lower right lobe of the lung was extremely rare and atypical for a large pneumoconiotic opacity. She conceded that the security of her assessment was further weakened by the lack of additional diagnostic tools such as CT scans and multiple x-rays to confirm the diagnosis of the opacity as complicated pneumoconiosis, rather than a quite probable primary bronchogenic neoplasm, i.e. cancer, or asbestosis. In this regard the failure of Dr. Patel to identify so large an opacity, even if at an earlier stage of development, on the x-ray taken just nine months earlier is inconsistent with the character of coal workers' pneumoconiosis as a progressive, incurable disease.

There is no evidence that Dr. DePonte had seen the earlier x-ray film interpreted by Dr. Patel, and it may be inferred that the absence of the large opacity on that film would have affected her diagnosis in light of the progressive and incurable character of coal workers' pneumoconiosis. Her statement that Claimant did not have the small rounded opacities typical of black lung, which could have coalesced into a conglomerate mass also militates against coal workers' pneumoconiosis. Moreover, although Dr. Wheeler's interpretation of the January 31, 2002, x-ray tends to confirm the existence of the four centimeter opacity, it also tends to support Dr. DePonte's reticence regarding her diagnosis, because of Dr. Wheeler's recommendation for CT follow up, and clear implication that the opacity was unrelated to pneumoconiosis. Thus, proof is essentially limited to the indication that there is a four centimeter opacity of dubious character in the uncharacteristic area of Claimant's right lower lung, which one interpreter indicates is not related to coal workers' pneumoconiosis, and which the other opines is very unlikely related to complicated pneumoconiosis. In the absence of corroboration, such evidence does not rise to a preponderance of proof of the existence of complicated pneumoconiosis based upon the evidence pertaining to that large opacity. Consequently, there is a failure of proof of complicated pneumoconiosis under §718.304(a) with respect to the January 31, 2003, x-ray read by Dr. DePonte.

Causation

In addition to establishing the existence of pneumoconiosis, a claimant must also establish that his pneumoconiosis arose, at least in part, out of his coal mine employment. Pursuant to §718.203(b), a claimant is entitled to a rebuttable presumption of a causal relationship between his pneumoconiosis and his coal mine employment if he worked for at least ten years as a coal miner. In the instant case, Claimant established at least twenty-three years of coal mine employment. Employer adduced no evidence which rebuts this claim. Thus, Claimant is entitled to the rebuttable presumption that such pneumoconiosis as he has arose from his coal mine employment under the provisions of §718.203(b).

Total Disability Due to Coal Workers' Pneumoconiosis

To establish entitlement, a claimant must prove by a preponderance of the evidence that he is totally disabled due to pneumoconiosis. A miner is considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. §718.204(c)(1). Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition, or it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. *Id.*

Dr. Rasmussen opined that the Claimant's twenty-three year history as a coal miner caused the complicated pneumoconiosis based on the large opacity identified by Dr. Patel in his interpretation of the March 29, 2001 x-ray. Dr. Patel identified pneumoconiosis based in part on small opacities classified as 2/1, t/t. Dr. DePonte classified her findings regarding small opacities as 1/0, s/t, opining that these irregular opacities were not characteristic of coal workers' pneumoconiosis. Dr. Rasmussen's opinion that, in effect, Claimant is totally disabled due to coal workers' pneumoconiosis is unpersuasive in a number of respects. His diagnosis of complicated coal workers' pneumoconiosis, with its attendant irrebuttable presumption derived in part from Claimant's twenty-three years of coal mine dust exposure, falls with Dr. Patel's x-ray interpretation, upon which it depends.

Although none of the pulmonary function tests or arterial blood gas studies of record are qualifying under the pertinent regulatory standards, Dr. Rasmussen's assessment of pulmonary disability based on the objective laboratory tests which he administered is a reasoned, objectively based medical opinion which supports a conclusion of total pulmonary disability. However, Dr. Rasmussen's assessment of the cause of that pulmonary disability is equivocal. Dr. Rasmussen declared that there are probably two risk factors for Claimant's impaired function. He identified these as Claimant's previous pleural effusion/fibrosis, which is not occupational in origin, and his coal mine dust exposure, which Dr. Rasmussen characterizes as "a significant contributing factor." Dr. Rasmussen identified Claimant's complicated pneumoconiosis and chronic bronchitis, which, being caused by coal mine dust, would qualify as legal pneumoconiosis, as the conditions to which Claimant's coal mine dust exposure is a significant contributing factor. He did not suggest or imply, however, that simple coal workers' pneumoconiosis has a significant role in Claimant's pulmonary disability.

Since Dr. Patel's x-ray interpretation diagnosing complicated coal workers' pneumoconiosis based on the large opacity in the upper left lung has been impeached, it follows that the elimination of complicated pneumoconiosis as a disabling factor undermines the validity of Dr. Rasmussen's conclusion that Claimant's pulmonary disability is attributable to coal mine dust exposure. There is no evidence that Claimant's chronic bronchitis is itself a disabling condition to which coal dust exposure was a significantly contributing factor, or that, as such, it so aggravated another condition so as to render Claimant totally disabled. The effect of the pleural effusion/fibrosis upon Claimant's moderate loss of lung function is unquantified and unknown on the instant record. Beyond the mere mention of chronic bronchitis as caused in part by coal mine dust exposure, Dr. Rasmussen does not assess its character or significance as a

disabling factor. Indeed, there is no characterization in Dr. Rasmussen's assessment that would affirmatively support a conclusion that the Claimant's chronic bronchitis alone has any disabling effect. Nor is there any proof that the bronchitis would worsen any other disabling pulmonary condition so as to cause the moderate loss of lung function described by Dr. Rasmussen. Consequently, this tribunal concludes that Dr. Rasmussen's medical opinion does not establish that Claimant is totally disabled by coal workers' pneumoconiosis.

Attorney's Fee

The award of an attorney's fee under the Act is permitted only if benefits are awarded. Since benefits are not awarded in this case, the Act prohibits the charging of any fee for representation in pursuit of the claim before this tribunal.

ORDER

The claim of Otis John Fields for black lung benefits under the Act is denied.

A
EDWARD TERHUNE MILLER
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the **Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601**. A copy of this notice must also be served on Donald S. Shire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.